Communication Activity Authorization Document

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Bureau for Global Health
US Agency for International Development

I. EXECUTIVE SUMMARY

This document authorizes a cluster of GH Bureau-wide communication activities. The activities will contribute to the Activity Objective (AO) – **Employ communication effectively for improving health, stabilizing population, and advancing a health competent society.**

The sector-wide activity will support the communication components of the five strategic objectives of the GH (Global Health) Bureau, Regional Bureaus and the GH Strategic Objectives of the United States Agency for International Development (USAID) Missions. Communication tools will range from large-scale mass media and social marketing programs to more targeted group and community behavior change interventions, networking and communication for social change, as well as interpersonal communication. Activities will help develop models of communication that address longer term and sustainable normative shifts in behaviors and policies beyond the individual level such as community mobilization, networking, and communication for social change.

The results of this activity will be measurable changes in key behaviors, social norms, and policies among target populations. Examples include: increased and continued rates of contraceptive use, improved immunization rates; policies that support increased consumption of vitamin A and other micronutrients; social norms of increased rates of breastfeeding; a system with trained attendants at birth; correct bednet use; hand washing and other hygiene behaviors; increased and correct use of Directly Observed Treatment, Short-course (DOTS) and of antibiotics, especially treatment for Acute Respiratory Diseases (ARI). Communication also will address the cluster of activities necessary for behaviors around Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) care, prevention, support and treatment with particular focus on reduction of stigma and unsafe sexual practices as well as increased condom use.

This activity will be carried out over ten years. During this period USAID and its contractors/grantees will identify and work with in-country implementing partners and institutions with the aim of increasing their capacity and shifting away from USAID's primary reliance on US-based contractors/grantees. To accomplish this shift the activity contains institution strengthening, capacity-building and training components to increase the ability of countries to carry out effective communication interventions. At the same time it includes increased support to USAID Missions to design communication projects.

II. RATIONALE

USAID has more than 30 years experience in health communication. USAID research and programs have contributed to significant public health successes including applications of communication programs in the field of family planning, the use of oral rehydration solutions for diarrhea, social marketing of contraceptives and other health products, and improved counseling and health worker-patient relations. The behavior changes resulting from these communication

interventions together with advances in public health such as new vaccines and treatment protocols contributed to significant decreases in maternal and child mortality and morbidity.

USAID communication programs have traditionally been designed to focus mainly on communication at the individual level. Increasingly, however, USAID-supported programs, most notably Non-Governmental Organizations (NGO), are applying group and community communication techniques. In some instances the community may be the city, town or village. In others the community may be a neighborhood or an extended network of persons of the same ethnic or racial group. Group and community activities focus on longer-term, normative shifts in behaviors among wider populations, for example safer sex, nutrition/food security, or environmental protection.

USAID's experience and research show that targeted individual approaches and participatory community approaches are necessary for successful public health interventions.[1] Research is not conclusive that either approach has better results than the other does; the objectives usually are different.[2] Research does show however that multiple methods work best.[3] Programs under this activity are expected to use individual and community approaches as well as other, more recent developments such as networking to speed the diffusion of change and innovation.

USAID programs pioneered the use of new technologies in health communication. Radio, television and the newer tools of Internet and CD-ROMs play important roles in increasing reach and reducing the costs of communication in the public health arena. While substantial barriers still prevent major segments of the population from seeking or using new technologies, the new media, characterized by interactivity, can provide proactive, individualized, and personalized information to the public, high-risk persons, patients, policymakers and providers. The Science Panel on Interactive Communication and Health concluded that few other health-related interventions have the potential of interactive health communication to simultaneously improve health outcomes, decrease health costs, and enhance consumer satisfaction.[4] Under this activity USAID will continue to pioneer the effective application of information technology to achieve public health objectives. In this effort, newer communication technologies will join older, proven strategies such as mass media, interpersonal communication and targeted print communication.

USAID has learned that communication works best when it is a part of a larger public health initiative.[5] Communication can influence the public agenda, advocate for policies and programs, promote positive changes in the social, economic and physical environment, stimulate debate and dialogue for health as a priority, and encourage social norms that benefit health and quality of

[1] Scott Ratzan, "Global Population, Health and Nutrition Communication: A Review of the Literature," presentation at USAID Communication Stakeholders Meeting, Washington, DC, 14 December 2000.
[2] Nancy Morris, "Bridging the Gap: An Examination of Diffusion and Participatory Approaches in Development Communication" paper presented at USAID Communication Stakeholders Meeting, Washington, DC, 14 December 2000.
[3] Thomas Backer and Everett Rogers, Organizational Aspects of Health Communication Campaigns: What Works? (Newbury Park, CA: Sage, 1993).
[4] Thomas Eng and David Gustafson, Science Panel on Interactive Communication and Health. *Wired for Health and Well-Being: the Emergence of Interactive Health Communication.* (Washington, DC: US Department of Health and Human Services, US Government Printing Office, 1999).
[5] Dina Towbin, "A One-Day Consultation Meeting on Communication in the Population, Health and Nutrition Sector for USAID Staff and External USAID Partners," report from meeting, Washington DC, 14 December 2000.

life. Communication can facilitate better health care at the individual, community, family and system level, but it cannot deliver facility-based clinical/technical services, counseling, and supplies. For this reason communication programs under this activity will be closely coordinated with programs to improve quality and access to services, strengthen institutions, and formulate effective policies for reproductive, maternal, child health, nutrition, HIV/AIDS and infectious diseases.

USAID has experimented with several ways of integrating communication within GH programs. For more than twenty years the Office of Population (POP) has supported contraceptive social marketing, a large project with a specialized communication activity Population Communication Services (PCS), and smaller communication activities within other reproductive health projects. The Office of Health and Nutrition (HN), on the other hand, moved back and forth between supporting a project with a specialized expertise in communication, albeit on a smaller scale than POP, and integrating communication within its flagship projects for maternal and child health and nutrition. Currently almost all HN flagships and specialized projects (BASICS II, MOST, MNH, EHP, FANta, Linkages) have some communication activities. In addition the CHANGE Project develops new tools and approaches for behavior change, including communication. The HIV/AIDS Division has placed behavior change, social marketing, and communication activities in a variety of its projects (AIDSMark, Alliance and IMPACT) but has no project with a specialized communication activity.

Integrated models and projects with a specialized function or expertise for managing communication activities each present challenges. Evaluations of the latest round of HN flagships (BASICS, EHP, OMNI) identified weaknesses in the integrated design, limiting the effectiveness of implementing communication activities and especially of taking these activities to scale.[6] The recent evaluation of the specialized POP communication activity suggested improved coordination is necessary between Cooperating Agencies (CAs) in the GH Bureau.[7] This activity will need to have the ability to go to scale while coordinating and integrating its activities with other service delivery CAs.

In setting the stage for the design of this AAD, USAID convened a roundtable discussion with field representatives, academics and communication practitioners in 1998 to explore and develop quality standards for health and development communication. The standards were to be used to assess the potential effectiveness and efficiency of health and development communication interventions. The group agreed that a quality health communication program: 1) is evidence-based, 2) includes and analyzes trend data, 3) focuses on promoting informed dialogue and choice, 4) effectively 'frames' an issue[s], 5) is ethical and transparent, 6) contains partnerships, 7) promotes local "ownership", 8) has a structured planning framework, 9) includes substantial resources for evaluation, and 10) works toward sustainability. [8] Evaluation findings and recommendations of USAID projects have supported the importance of these components.

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[6] Interim Evaluation of the BASICS Project (Washington DC: TvT Associates, Inc., 1997);
Interim Evaluation of the Environmental Health Project (EHP) (Washington, DC: TvT Associates, Inc., 1997); "Behavioral Dimensions of Maternal Health & Survival," summary of a consultative forum co-sponsored by MotherCare, the CHANGE Project, and the World Health Organization, (no date).

[7] Evaluation of the Population Communication Services (PCS) Project, 1995-2000 (Washington DC: LTG Associates, Inc., 2001).p.37.

[8] More details on each of the quality standards is available at www.comminit.com/review_qualitystandards.html.

The increasing complexity of health communication, including new definitions of health, evolution of new media and the needs of diverse audiences demands broad, interdisciplinary, multi-sectoral approaches. A recent Institute of Medicine (IOM) report, *Bridging Disciplines in the Brain: Behavioral and Clinical Sciences*, observes, "Solutions to existing and future health problems will likely require drawing on a variety of disciplines and approaches in which interdisciplinary efforts characterize not only the cutting edge of research but also the utilization of knowledge."[9] Likewise the PCS evaluation suggests the need to apply more recent and innovative communication theory as well as to strengthen the links between outreach activities and community-based support groups to ensure sustainable impact.[10]

Better planning and design frameworks and expertise are needed to manage these complex, interdisciplinary health communication interventions. Experience suggests the integration of communication at the strategic framework and planning level of the Missions as the best way to maximize the successful use and impact of communication interventions. An independent survey of USAID PHN officers managing communication programs, however, revealed little formal training and few resources available for the design and management of communication activities in the field.[11] In response to these and other findings, the new communication AAD will foster broad, interdisciplinary approaches to health communication, and support the missions in assessing country communication needs and program design and implementation.

Partly as a result of USAID's significant investment in the field, communication has become a mature discipline in the United States, containing tried and true theories, interventions, processes, competencies and techniques.[12] Thirty years of investment in organizations and partners who have focused on many facets of communication and behavior change has produced many successes in terms of clients and consumers understanding and use of contraceptives, Oral Rehydration Therapy (ORT); hand and food washing; condoms to prevent HIV/AIDS and Sexually Transmitted Infections (STI) as well as improved counseling from family planning /reproductive health (FP/RH) providers. One area, however, where more work needs to done is building the capacity of local communities and institutions. A recent evaluation of USAID's micronutrient portfolio found that although many projects identify [communication] capacity building as part of their goals and workplan, it often gets lower priority status as the need for "getting the work done" takes precedence.[13] More attention must be given to appropriate external technical assistance and partnering with universities, training institutions, private sector media and NGOs that can train professionals and carry out programs in a sustainable manner.

The Communication AAD addresses the issues described above by:

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[9] Terry Pellmar and Leon Eisenberg, (eds.) "Bridging Disciplines in the Brain, Behavioral and Clinical Sciences," (Washington DC: Institute of Medicine, National Academy Press, 2000)p. 1.
[10] PCS Evaluation, 2001, p. 10.
[11] Susan Mach, "Voices from the Field: Communication for Development," paper prepared for the Joint Rockefeller Foundation/USIAD Conference *Communication for Development*, Bellagio, Italy, October 2000.
[12] Everett Rogers, "The Field of Health Communication Study Today: An Up-to Date Report," *Journal of Health Communication: International Perspective* 1: 1 (1996).
[13] Review of USAID's Micronutrient Portfolio, (Washington DC: HTS, 1997) p. 51.

1. Using both individual and community approaches as well as other, more recent developments such as networking and communication for social change to improve the impact of communication activities and facilitate exchange and innovation.
2. Coordinating communication activities with local programs and institutions that improve quality and access to services, strengthen systems, and formulate effective policies.
3. Fostering broad, interdisciplinary approaches to health communication and supporting the design and management processes necessary to make them successful.
4. Focusing appropriate technical assistance and partnering with universities, training institutions, private sector media and NGOs to improve the sustainability of institutions for health communication in developing and transitional countries (hereinafter for simplicity this document refers to all USAID supported activities as taking place in "developing" countries).

The need for increased integration of individual and community-level communication activities will be met with a large program to implement at-scale communication and social marketing programs using state-of-the-art mass and interpersonal media as well as participatory and community-led interventions. This communication activity will respond to global and field program demands for national and regional communication strategies, campaigns and programs. To carry out this mandate more effectively and build capacity in countries, the program will work with a wide range of local and national media and talents, such as commercial and community media, marketing communication, and research firms in the south.

The need to coordinate communication activities with service delivery, policy, research and other areas in the USAID portfolio and foster broad, interdisciplinary approaches will be met with an increased GH Bureau in-house capacity in communication. A GH communication professional will work under the Result 1 CTO (Cognizant Technical Officer) to ensure appropriate linkages are made with flagship CAs and will also ensure that the latest technical findings in the areas of FP/RH, child survival and maternal mortality, and HIV/AIDS and infectious diseases, are available to and used by the communication program as well as other cooperating agencies implementing communication programs. Additionally, select USAID bilaterally-funded communication activities will be identified and analyzed to ensure innovations and best practices are shared along with lessons learned and potential barriers to success.

Over the ten years of this activity, USAID plans to address the need for sound institutional growth in health communication in developing countries by initially partnering and eventually devolving health communication to appropriate in-country institutions. The awards under this AAD will contain specific requirements and measures to insure this "devolution" to in-country institutions. A regional or national consortium of public health and communication schools and subsequent networks of health communicators, for example, could fill the need for human resources while providing research and programmatic implementation capacity. The capacity building component under this communication activity will work closely with other donors and multilateral organizations including the World Health Organization (WHO), the Pan American Health Organization (PAHO), WHO-Euro, Soros, and the Rockefeller and the Bill and Melinda Gates Foundations to achieve these leadership goals. Activities under this AAD will receive field and regional bureau resources to help develop templates, core curriculum, South-South

support and regional coordination, working closely with other programs already addressing this need.[14]

Finally, the activities in the AO to "employ communication effectively for improving health and stabilizing population" will be ongoing. "Advancing a health competent society" is a conceptual rubric that assists in sustainability of health communication interventions. The devolution of activities amongst individuals, community, governmental and related organizations in country is a goal of health communication. Ideally, a health competent society is composed of active individuals who are health literate, a community that supports and encourages healthy activities, a supportive environment for healthy public policy (sound civil society), and a system with adequate capacity (human and economic) to deliver preventive and curative health services.

III. FRAMEWORK

This AAD seeks to integrate over 30 years of USAID experience in health communication with the needs of the field in the 21st Century. The activity reflects advances in theory and in evidence-based practices of health and communication from the public and private sectors alike along with the latest recommendations in the field of public health.

> "Rather than focusing interventions on a single or limited number of health determinants, interventions on social and behavioral factors should link multiple levels of influence (i.e. individual, interpersonal, institutional, and policy levels)."[15]

A GH Bureau-wide activity, the Communication AAD is a cluster of programs within the overall Agency strategic goal of "World Population Stabilized and Human Health Protected." Communication is present across a wide range of GH priorities – improved preventive, acute and chronic care, supportive social and physical environments, increased education and income, reduced vulnerability/risk factors, and improved health system performance and quality. The activity contributes specifically to GH's five SOs.

SO 1*: Increased use by women and men of voluntary practices that contribute to reduced fertility;*
SO 2: *Increased use of key maternal health and nutrition interventions;*
SO 3*: Increased use of key child health and nutrition interventions;*
SO 4: *Increased use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic* and
SO 5: *Increased use of effective interventions to reduce the threat of infectious disease of major public health importance.*

The AO for this Communication AAD is to **employ communication effectively for improving health, stabilizing population, and advancing a health competent society.** Programs under the Communication AAD will achieve the following three results:

[14] USAID/PERU Strategic Plan 2002-2006, 15 December 2000.
[15] Institute of Medicine, Promoting Health: Intervention Strategies from Social and Behavioral Research. Recommendation 2. Brian Smedley and S.Leonard Syme (eds) (Washington DC: National Academy Press, 2000) p.9.

Result 1 **Communication programs to influence social norms, community and individual behaviors, institutions and policies for population, health and nutrition implemented.**
Result 2 **Country-level leadership to deliver communication programs enhanced.**
Result 3 **Information, knowledge and best practices for family planning/reproductive and other health areas accessed by multiple audiences.**

Programs under this AAD will address the specific target populations and key behaviors of the five GH SOs. In addition, the AAD will support an agenda of research, innovation, design, evaluation and capacity building. The Communication AAD is not GH Bureau's only activity using communication. Other projects supported by the GH Bureau will continue to have communication capabilities. The role of the Communication AAD will be to spearhead the Bureau-wide roles of strategic planning, full-scale program implementation, training and capacity building in communication. Result 1 will be supported through a mix of core, field support and mission-based procurement actions. Result 2 will be primarily supported through field support and mission-based procurement actions. Result 3 will be primarily supported through POP core funds with some field support and mission-based procurement actions. (See the Financial section for additional details on funding).

The Bureau-wide nature of this AAD will enhance a number of interrelationships of results and activities that may include:

- Integrating HIV/STI and family planning efforts;
- Building linkages between health communication activities and service delivery and mobilizing and leveraging funds for cross-sectoral activities from other sectors and donors (e.g. Democracy and Governance (DG), disaster relief);
- Promoting sustainability by creating an environment for in-country institutions to develop networks to enhance diffusion and replication of successful interventions;
- Developing an enabling environment for health communication activities among leading organizations in the field.

IV. RESULTS, ACTIVITIES AND MONITORING

The Communication AAD has three results. Outcomes, activities and monitoring under each result and their illustrative sub-results are described below.

Result 1 **Communication programs to influence social norms, community and individual behaviors, institutions and policies for population, health and nutrition implemented.**

- Illustrative Sub-Result 1.1 Improved capacity for strategic planning, program design, and monitoring and evaluation of communication programs.
- Illustrative Sub-Result 1.2 Effective, evidence-based communication programs implemented at scale.
- Illustrative Sub-Result 1.3 Effective integration of communication within wider public health programs.

- Illustrative Sub-Result 1.4 Qualitative and quantitative formative, operations, and summative research conducted for ideal communication interventions.

Illustrative Sub-Result 1.1 Improved capacity for strategic planning, program design, and monitoring and evaluation of communication programs.

Result 1 is designed to address institutional, system, environmental, and individual levels. This GH Bureau-wide activity may develop evidence-based templates for communication approaches and tools as a USAID brand for effective programmatic impact. For example, GH Bureau CAs could be involved in developing, refining, disseminating and applying state-of-the-art USAID communication approaches and tools to help develop the capacity of developing country evidence-based/branded approaches. In marketing terms, this could be referred to as extending the reach of the USAID's brand for strategic communication. CAs developing culturally appropriate branded tools are likely to be more relevant and useful to end users because of their systematic research components and multi-disciplinary approaches, in-depth field testing within local contexts, and the combination of CA expertise with specialized contextual expertise in areas such as stigma for certain diseases (e.g. HIV/AIDS, tuberculosis (TB), etc.) or in areas of reproductive/maternal health.

Additionally, USAID requires an in-house, multi-disciplinary technical capacity to manage its growing portfolio of communication activities more effectively. The need for an increased strategic planning capability for communication programs was identified in the process of designing this AAD by GH personnel and PHN officers and Foreign Service Nationals (FSNs) in Missions.[16] Missions, however, rarely are able to hire or access this type of expertise. This AAD includes mechanisms to develop this capacity with country-level counterparts as well as to assist USAID at the headquarters and Mission levels. (See Management section for further description.)

USAID Missions' need for increased knowledge and skills for the design and management of communication activities will be met by the development and dissemination of programmatic planning, implementation and evaluation tools.[17] This activity also could provide in-service training at Mission retreats and regional PHN State-of-the-Art (SOTA) workshops on areas such as the integration of new (e.g. internet) and old (e.g. telephone) communication technologies. Regional or country workshops could involve a cross-section of staff from Missions and USAID partners related to a specific activity. In Missions where communication has a visible and active role in the portfolio, actions under this sub-result could provide support for strategic communication planning, and design.

[16] PCS Evaluation, 2001; Mach, 2000; Survey of USAID PHN Field Officers, November 2000.
[17] The CDC has developed their "brand"/model of strategic communication with a CD-ROM training tool called CDCynergy. All Centers and contractors must follow the model/template when implementing communication programs.

The results of Sub-Result 1.1 will be improved design and implementation of more relevant and cost-effective communication programs within countries, in USAID Missions, and amongst USAID and non-USAID partners. These results will be monitored against a series of benchmarks including: development of planning models, cost-effectiveness models, standardized tools, and application of integrated strategic frameworks for communication programs.

Illustrative Sub-Result 1.2 Effective, evidence-based communication programs implemented at scale.

This sub-result currently represents the main area of operation of the communication project housed in the POP Office. The HN Office, on the other hand, lacks this large-scale implementation capability, and Missions often depend on the POP CAs for field activities or do not conduct at-scale communication activities at all.[18] USAID will award a cooperative agreement to a consortium with the technical capacity to carry out large-scale programs across the USAID Missions in collaboration with governments, NGOs and the private sector. These institutions will have expertise in or access to the appropriate technical capacity in the relevant fields of public health as well as to the in-country implementation agencies (media, research, and creative talent). Over the ten years of the life of this AAD the locus of communication activity implementation will gradually devolve to the developing countries (see Result 2).

Innovative and science-based communication strategies that will be employed under this sub-result include media and policy advocacy, social marketing, public relations, negotiation, mass-media campaigns, interpersonal communication, entertainment-education, community mobilization, and other participatory approaches. Programs will apply the over arching principles of strategic communication and may include a balance between campaign-type programs and new approaches. A recent IOM study on promoting health, for example, advised that efforts to develop the next generation of prevention interventions must focus on building relationships with communities and developing interventions that derive from the communities' assessments of their needs and priorities.[19] At the same time, the BASICS evaluation cautioned USAID not to reject proven mass-media models in favor of more experimental community participation models, but to use both models in a complementary fashion for improved efficacy.[20]

Another strategic area of communication under this sub-result will be the use of audience segmentation, a hallmark of social marketing. Successes in communication have emphasized population segmentation,[21] recognizing the need to develop differentiated strategies for various sub-groups in regions and settings. Epidemiological, psychographic, demographic and sociometric variables offer a multitude of opportunities for segmentation, all of which have an evidence base for success.[22] Reaching an illiterate population in South Asia and a similar educated cohort in Eastern Europe, for example, requires different approaches. Effective

[18]Survey of USAID PHN Field Officers, November 2000.
[19]IOM, Recommendation 18, 2000, p.29.
[20] BASICS Evaluation, 1997, p.33.
[21] Vicki Freimuth, Huan Linnan, and Polyxeni Potter, "Communicating the Threat of Emerging Infections to the Public," *Emerging Infectious Diseases Journal*, 6:4 (2000).
[22] Scott Ratzan, (ed.) Health Communication: Challenges for the 21st Century. *American Behavioral Scientist*, 1994.

communication will test and support appropriate approaches for reaching audiences of different age groups, gender identification, marriage status, education level, refugee status, health behaviors/norms, culture, and the socially marginalized, all of whom are at special risk for a multitude of health issues. Such evidence-based, multi-disciplinary strategies could advance individual health literacy thereby contributing to the outcome of a health competent society.[23]

Illustrative Sub-Result 1.3 Effective integration of communication within wider public health programs.

This activity mainly will addresses the key behaviors identified within the five SOs at the individual, community and policy levels. Ideally, however, interventions will help individuals develop the general cognitive and social skills to promote their own health and that of their families, navigate the health care system, and understand the language of health care providers. The result of Sub-Result 1.3 is a more supportive environment for health. This implies that people more effectively participate in decisions about their health, working with community groups, public-private partnerships, and other interested parties. With the aid of new information technologies, communication can facilitate future scenarios where the public, providers, or the media could elicit or provide accurate, up-to-date "health information" for integration into daily health practices.

Programs under this sub-result will be based on a wider lifecycle and/or dual protection perspective. The former implies developing health literacy at a level commensurate with age, mental capacity, gender, and environment. For example, youth can learn about health and hygiene, nutrition and physical activity while learning about reproductive health behavior. The latter implies addressing more than one function of a specific tool, for example, promoting condoms for family planning and for preventing HIV/AIDS and STIs. Communication can support learning opportunities during immunization experiences such that families and recipients understand the disease preventive and public health benefit of immunizations (and in some cases Vitamin A). As a person ages, an acquired health literacy skill can continue to enhance knowledge and practice and ultimately the health of the public. The integration of research – qualitative and quantitative – will assist the strategic development of health literacy addressing barriers, examining indicators and gauging success.

Sub-Result 1.3 also will support programs that actively engage the public and private media in public debate and dialogue on health issues and behaviors. The media industry in partnership with the public health agenda can promulgate health (and wealth) through civic responsibility, global citizenship, environmental justice, gender equality, and health competencies as part of their basic goods and services.

"Social capital" is another area to be explored under Sub-Result 1.3. This umbrella concept has been defined as "the resources embedded in social relations among persons and organizations that facilitate cooperation and collaboration in communities."[24] Studies suggest that communal activity and community sharing translates into better health. Evidence suggests that

[23] Catherine Selden, et al, (compilers) Health Literacy Bibliography. (Bethesda, MD: National Library of Medicine, 2000).
[24] K Lochner, et al., "Concepts of Social Capital: Approaches to Measurement. *Health and Place*, 1999.

communities with less social capital have lower educational performance, more teen suicide, higher prenatal mortality, and lower birth weight.[25] An IOM publication on promoting health suggests that the media and marketing strategies present a "lever" to enhance social capital. Traditional behaviorally oriented media campaigns, the author notes, have had limited effectiveness in creating and sustaining significant behavior change. Media, however, do have the potential to address more fundamental aspects of the social context in which health behaviors occur, most significantly by enhancing involvement in civic life and encouraging social justice, participation, and social change, thereby contributing to community mobilization to advance public policies that promote health.[26] The Rockefeller Foundation's "Communication for Social Change" initiative has demonstrated evidence of success as a bona fide approach to create social capital.

Initially the communication consortia will carry out programs under Sub-Result 1.3. As in-country capabilities grow, this function will be transferred to developing country institutions.

Illustrative Sub-Result 1.4 Qualitative and quantitative formative, operations, and summative research conducted for ideal communication interventions.

This sub-result will support efforts to develop research and evaluation to better implement communication programs, training and performance improvement activities, and to demonstrate impact/results. Communication science methodologies include formative research--client needs and preferences, political/social/family context–as well as mechanisms for incorporating these into the design, development, and implementation of program design and execution. Health communication activities may be organized into a formal program to share local experiences, provide specialized technical support, and manage resources. These activities could also be integral to the developing country Centers Of Health Communication (COHC) (see Result 2) and also Result 1 with a consistent enhancement of field-based experiments that refine existing methodologies or develop new approaches.

Many health communication activities are designed with a variety of incentives and disincentives for individuals, providers, institutions and policymakers. Research is necessary at every stage of the communication process to support and sustain the desired outcome for health competence. Appropriate communication research can identify ideal strategies for performance incentives at the system or individual level and also identify the necessary environmental (and in some cases economic) structures that can be enhanced. Ideally, this research and subsequent application will optimize communication effects.

The core-supported component of this sub-result will contain a research agenda that will address Bureau-wide needs as well as specific issues within each SO, including the following illustrative list of issues:

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[25] Ichiro Kawachi and LF Berkman. "Social Cohesion, Social Capital, and Health," in *Social Epidemiology*, LF Berkman et al., (eds.) (New York: Oxford University Press, 1998).

[26] Lawrence Wallack, "The Role of Mass Media in Creating Social Capital: A New Direction for Public Health," in *Promoting Health: Intervention Strategies from Social and Behavioral Research*, B.D. Smedley and S.L. Syme (eds.) (Washington, DC: Institute of Medicine, National Academy Press, 2000).

1. Analyzing the cost-effectiveness of communication interventions;
2. Assessing dose effects of communication interventions, assessing the incremental effects of each component of multilevel, comprehensive interventions and the incremental effects of interventions over time. Such analyses should consider the broad influence and costs of interventions to target individuals, their families, and the broader social systems in which they operate[27];
3. Improving quality of interpersonal communication such as quality of service delivery, providers' communication skills, participatory methodologies, health literacy, peer exchange among others;
4. Increasing understanding of the impact of culture and gender on the success of communication interventions;
5. Developing new models and measurements of community participation;
6. Gathering and proliferating best practices for sustaining communication campaigns (corporate sponsorship, community ownership, etc.);
7. Assessing and facilitating introduction of information technology at all levels of health communication; and
8. Exploring the needs of special audiences.

Further, the multi-disciplinary research approach will merge the knowledge and know-how of mature disciplines in the North--public relations, media studies, advocacy, social marketing, and community participation/negotiation, public policy etc.--with the health communication expertise in the South. In many ways, the research element is key for Result 1. However, its application in Result 2 advances the overall sustainability as well as the necessity for integration of communication research at the proximal level of influence. In every case the communication research could assist in the development of a multi-pronged approach: partnerships; global leadership; operations and evaluation research; and capacity building, in order to achieve the greatest possible progress in each of the results. The following list is illustrative and dependent upon funding for each SO:

SO1: *Increased use by women and men of voluntary practices that contribute to reduced fertility.*
Increasing demand: Research will address how communication variables and activities improve quality of services and client/provider interaction as well as the integration of cultural traditions and beliefs—adapting normative behavior. Communication/Social marketing research will help refine audience segmentation for improved message reception and more effectively reach youth, partners, social networks, and the community at large. Finally, evidence based research can be employed to dispel misconceptions and myths about methods.

Exploration of communication variables that lead to a decrease of contraceptive discontinuation rates and the activities necessary to sustain use and reverse misuse can also be developed.

SO2: *Increased use of key maternal health and nutrition interventions.*
Advocacy: Research will develop and test advocacy tools to include practical, actionable recommendations for interventions at the community, regional, policy, and national level.

[27] IOM , Recommendation 17, 2000, p.29.

Connecting women with services: Research will address how to use communication more effectively to reduce the cultural, physical and other barriers to women seeking services or adapting healthy behaviors.

SO3: *Increased use of key child health and nutrition interventions.*
Immunization: The main areas of research include how to use communication more effectively to: generate and sustain demand among child caretakers for immunization services; improve bottom-up or participatory planning to reach high-risk populations and promote community ownership and support. Other areas are how to use communication to build inter-sectoral alliances and widespread participation of community-level influentials and organizations, administrative authorities, and institutions to support specific initiatives such as polio eradication and periodic measles and tetanus campaigns and enhance the longer-term sustainability of health system immunization services. Finally, as with all SO3 activities, research will address how to improve the communication skills of health workers as service providers and supervisors or managers.

Nutrition: Research will address how to employ communication more effectively for behavior change activities at household, community, policy, and health system levels and how to link community-based nutrition interventions with the larger health system.

Integrated approaches to child health: Research will address how to employ communication more effectively to improve caretaker practices within the household – recognizing severe illness, seeking appropriate care, compliance with treatment recommendations, maintaining good home hygiene as well as the effective use of communication to address barriers to compliance, implemented through various community agents, health workers, and targeted mass media.

Peri/neonatal health: Research will address how to employ communication more effectively to support community mobilization and participation, improve practices of healthcare providers, and increase the awareness of policy and decision-makers of the importance of newborn care and the need for appropriate programs.

SO4: *Increased use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic.*
Awareness and prevention: Research will address how communication can effectively help set the agenda for heightened community awareness, mobilization and participation, improve practices of healthcare providers, and increase the awareness of policy and decision-makers of the magnitude of HIV impact.

Research will develop and test advocacy and communication tools to include practical, actionable recommendations for interventions at the community, regional, policy, and national level in health settings, public discourse and policy environments.

Reducing stigma: Research will develop and evaluate communication interventions to reduce stigma, discrimination and hopelessness associated with HIV. Linkages with other SO efforts and dose effect of family planning, STI education, and emerging diseases will further be

explored for potential synergies and/or diluted effects. In particular, the role of culture as an asset and a barrier will be explored.

SO5: *Increased use of effective interventions to reduce the threat of infectious disease of major public health importance.*
Going to scale with successful interventions: In general, research will evaluate smaller-scale, experimental interventions to employ communication to change behaviors under SO5 and assess needed factors in order to take interventions to a larger scale. Cross-cutting research areas for SO5 are how to use communications more effectively to reduce stigma and increase patient compliance. In the case of malaria, research will address the issue of how to improve social marketing of products and change caretaker behaviors as well as group preventive behaviors within the family.

Result 2 Country-level leadership to deliver communication programs enhanced.

- Illustrative Sub-Result 2.1 In-service training and pre-service education for health communication developed in countries.
- Illustrative Sub-Result 2.2 Capacity developed in countries via COHC, networks and other activities.
- Illustrative Sub-Result 2.3 Qualitative and quantitative formative, operations, and summative research capacity and diffusion developed in countries.

The ten-year vision of the Communication AAD is the eventual devolution of the implementing capacity for health communication programs to developing country institutions. A parallel to this devolution will be the enhancement of the capacity of local institutions, partners, programs, and USAID Missions to manage large-scale health communication programs in countries and regions (Sub-Result 1.1). The outcomes of this result will be measured in terms of the improved capacity and sustainability of local and regional communication institutions and networks.

Additional discussions will take place within the GH Bureau to further delineate appropriate levels of funding and procurement mechanisms.

Illustrative Sub-Result 2.1 In-service training and pre-service education for health communication developed in countries.

USAID along with a score of international and bilateral agencies such as PAHO, the World Bank, the Inter American Development Bank, UNICEF, and the Rockefeller Foundation currently are supporting health communication programs in developing countries with high levels of funding. This sub-result would seemingly be a ripe area to develop partnerships amongst major donors seeking to impact communication capacity in country; to date, developing countries' capacity to implement health communication programs remains limited. There are only a small number of professionals in developing countries with advanced degrees in health communication theory, methods, practice, and research. In fact, while there has been significant development of health communication as a field in the United States, very few universities in developing countries offer undergraduate or graduate programs in this field.

Activities under this AAD will address the current shortage of health communication professionals in developing countries. It will build academic infrastructure and create regional self-sufficiency. By the end of the ten-year period we expect the research, planning, implementation and evaluation of health communication programs supported by USAID to be carried out in local and regional institutions. Activities under this sub-result could help develop templates, competencies, core curriculum, instructional design, technological applications, South-South support and regional coordination while working closely with Mission and other donor programs already addressing this need.

Programs under this sub-result could include:

- Support of universities as institutions and/or a consortium to identify core competencies and develop and implement degree and certificate program in health communication in schools of public health, communication and journalism.
- Support to improve programs, and practices, through site visits, exchange programs, lectures, on-line discussions, one-to-one local tutoring on topics such as communication for development, program planning and evaluation, partnership building, behavioral change theories and methods, use of epidemiological data, research design, curricular and faculty development, and program marketing.
- Development and testing of interactive multimedia and on-line exchange and education resources in health communication.
- Support to local, national, sub-regional and regional networks (real and electronic) of health communication scholars, practitioners, or journalists and connection with worldwide networks.
- Training of university faculty and training of trainer programs.
- Developing and enhancing partnerships that may include NGOs, multilateral institutions, national and local governments, and private organizations that promote the benefits of employing health communication professionals and support research and development projects.

Illustrative Sub-Result 2.2 Capacity developed in countries with COHC, networks and other activities.

In collaboration with field missions, Sub-Result 2.2 will provide support for building capacity by supporting and enhancing COHC and health communication networks in countries and regions. These institutions could be specialized by topic, for example, a COHC for HIV/AIDS, TB, or malaria, or by region. These centers will provide the essential infrastructure needed to facilitate rapid advances in knowledge about health communication, develop evidence-based strategies and tools for health communication, train tomorrow's health communication scientists and promote collaboration with medical centers of excellence and partnerships with advocacy groups, industry and commercial endeavors.

An important role of the centers will be to study how to maximize the impact of communication for health competence including social and behavioral elements. Capacity building in evidence based research – formative, operations and evaluation – will be supported in the in-service and pre-service training as well as amongst those professionals affiliated with the COHC. It is

envisioned that areas of communication expertise would emerge and be developed and their success could be diffused through out the region or globally. For example, a COHC might address HIV/AIDS with a specific communication intervention to reach illiterate women or other at-risk and under-served populations. Improved efficacy of public opinion polling, public relations, marketing communication, interpersonal communication, advocacy, community mobilization and media strategies will be hallmarks of the COHCs that influence health activities at the global, regional and local levels.

These Centers of Health Communication can be based in existing institutions, such as medical schools, schools of public health, communication or journalism or similar existing organizations. Depending on the infrastructure and status of such institutions in country, health communicators in the North will link with their counterparts at the COHC that may include people from academic, governmental and professional institutions. The centers and their counterparts will be strengthened by ready access to the information gathered and packaged under Result 3. This includes the internationally recognized health communication database that USAID has developed over ten years as well as new technological developments such as the internet. The Result 3 activities serve as the "core library" of materials for health communication interventions with CD-ROMs, evidence-based approaches, and multi-media archives.

A wide range of activities in communication can be developed in the form of networks. In resource-poor environments, health communication practitioners often work in a relative vacuum, and key public health information cannot be integrated by central authorities or by the people inputting information into the surveillance network. The COHC can link practitioners working in the field with public health academics and students. A network benefit includes capacity building through curriculum co-development, a process wherein North and South instructors develop parallel courses. The contents of these courses and their products are shared interactively by students and faculty, expanding the 'vision of the possible' in and outside the classroom.

Networks also can strengthen the ability of broadcast and newspaper journalists, government spokespeople, NGOs, health professionals, educators, and private sector communicators to enhance health literacy, promote healthy choices and behaviors, and influence public policy. The lessons learned since 1997 from the European Health Communication Network experience include activities of 51 WHO European Member States. This network created synergistic links as people in the networks develop appropriate health information sources linking distribution resources and appropriate agendas for their constituencies.[28]

Illustrative Sub-Result 2.3 Qualitative and quantitative formative, operations, and summative research capacity and diffusion developed in countries.

This sub-result will support efforts to develop research and evaluation capacity to better implement communication programs, training and performance activities, and to demonstrate

[28] World Health Organization (WHO) "The Pen is as Mighty as the Surgeon's Scalpel: Improving Health Communication Impact." Proceedings of the WHO European Health Communication Network Consultation on Health and Environmental Communication Policy, Moscow, 28-30 May, 1998.

impact/results. Communication science methodologies include formative research--client needs and preferences, political/social/family context–as well as mechanisms for incorporating these into the design, development, and implementation of program design and execution. Health communication activities may be organized into a formal program to share local experiences, provide specialized technical support, and manage resources. These activities could be integral to the COHC and also contribute to Result 1 with a consistent enhancement of field-based experiments that refine existing methodologies or develop new approaches. In summary, the development of capacity for research in Result 2 advances the overall sustainability as well as the necessity for integration of communication research at the proximal level of influence. The COHC and the people they train should continue to imbue the ideal approach to health communication activities. In every case, communication research could provide evidence for the ideal mix of strategic design and program implementation.

Result 3 Information, knowledge and best practices for family planning/reproductive and other health accessed by multiple audiences.

- Illustrative Sub-Result 3.1 Information on useful best approaches and findings identified, synthesized and made accessible.
- Illustrative Sub-Result 3.2 South-South and South-North "knowledge communities" and networks tapped and enhanced.
- Illustrative Sub-Result 3.3 Capacity of regional and local institutions enhanced to serve regional and local needs for information and dissemination.

Timely and accurate access to quality information is a fundamental pillar to evidence-based decision-making and the creation of knowledge used to design and implement programs and drive health policies. The Office of Population has supported the collection, development and dissemination of information and materials in the field of FP/RH and related areas for more than 25 years. These materials and information are disseminated to varied audiences within the development community, including developing country FP/RH program managers, service providers, researchers, academics, libraries, donors, foundations, communication specialists and the media.

Global distribution of information is now facilitated by information and communication technologies that improve audience reach, make time zones irrelevant, and facilitate access to information and knowledge from developing country counterparts that until very recently has been unrecognized or inaccessible. Developing country counterparts are also better able to access information that used to take weeks or months to request and receive. The future communication technologies' landscape will continue to change dramatically serving as a catalyst and a tool for improved exchange of information and a more complete knowledge base.

The awardee under this result will collect, synthesize and widely make accessible FP/RH information, best practices and knowledge stemming from an array of northern and southern partners that could include developing country professionals and organizations, USAID-funded CAs, Mission bilaterals, international donors, foundations and others. It will use a variety of technologies such as existing virtual networks, print, CD-ROM, e-publishing, video, audio, the internet, and other technologies, to encourage the multiple audiences described earlier to access a broader and more complete global knowledge base on population and family planning. This

result will also have the ability to expand beyond FP/RH and select health areas if additional interest and funding become available.

Illustrative Sub-Result 3.1	Information on useful best approaches and findings identified, synthesized and made accessible.

There is a wealth of FP/RH information, data and research findings available. For many, new technologies have made it easier and cheaper to access this information regardless of where it is physically stored, whether through the internet, wireless technology or a $1 CD-ROM. At the same time, these same technologies have proliferated the “birth” of new authors and publishers disseminating massive quantities of information. The average program manager and policy maker are often inundated with data and left unable to ascertain the source or degree of accuracy and quality of the information. The volume of information has given way to knowledge and information brokers and managers that sort through data, retrieve useful information and package it for a particular audience. Because different audiences have different expectations, skills and needs, information must be tailored in format, content and style.

Historically, the information and knowledge disseminated through USAID funded projects has been used to design national and local FP/RH programs, update technical content of training sessions, assist decision-making processes in the executive branch and Ministries of Health, and improve the accuracy and frequency of reporting by the media. It has also provided researchers, libraries and scientists with evidence-based studies, articles and bibliographies, and the most recent findings, applications and lessons learned in the population, reproductive and other health fields.

This sub-result is designed to anticipate and address the needs of the multiple audiences described earlier. The entity responsible for implementing this result would need to: 1) work with select GH Bureau CAs to help them better format, package and disseminate best practices and research findings; use appropriate technologies; and help reduce the incidence of duplication of materials by providing a forum for discussion and exchange of materials; and 2) cull through existing FP/RH information, publications, materials and information to synthesize and disseminate key concepts, findings and programmatic implications.

Under this sub-result, the implementer will use a variety of communication vehicles, such as journals, newsletters, other publications, CD-ROMs, kiosks, as well as a world wide web sites, portals, electronic media and newer technologies to provide scientific and technical reviews, and access to best practices and knowledge. Access to scientific, technical and programmatic literature and communication tools could also be provided through a communication media and materials clearinghouse, databases or other similar products.

Illustrative Sub-Result 3.2	South-South and South-North "knowledge communities" and networks tapped and enhanced.

Historically, developed country FP/RH specialists, researchers and policy makers have produced and disseminated family planning, reproductive health and primary health information to their counterparts in developing countries. The result has often been a “one-way street” in which information flowed mainly from developed countries to developing country professionals. The result has been missed opportunities to learn from the south.

New technologies now facilitate two-way horizontal exchange of information and dialogue through the creation of portals and development gateways. These gateways create platforms for users with the same interests to talk to each other. While not the solution to all those that seek improved access to information, it is one approach for the creation of "knowledge communities" where program planners, researchers, policy makers, communicators and others can acquire information, resources, and tools; contribute their knowledge and experience on specific topics; and share materials, dialogue, and solve problems with those working in the same areas. The result is improved communication, learning and the building of networks and communities of practice around significant development challenges.

Under this sub-result, “knowledge communities”, networks, and gateways will be accessed and used to disseminate and exchange information. These communication vehicles could also be enhanced or even created, if necessary, to improve communication among "knowledge communities" thus contributing to a worldwide common base of knowledge for practice and policy in the area of family planning, reproductive and other health interventions.

Illustrative Sub-Result 3.3 Capacity of regional and local institutions enhanced to serve regional and local needs for information and dissemination.

Improved communication infrastructure and the development of the Internet and other technologies give local institutions the opportunity to create, publish, and disseminate local information and knowledge; and the ability to access information produced in other countries more quickly and more affordably. The Office of Population has already contributed to improving the capacity of select developing country institutions to use some of the new technologies for information and dissemination. For example, Office programs (e.g. the Population Information Program) began to use and train local institutions in the use of CD-ROM technology over eight years ago. As a result, CD-ROMs containing up-to-date information on the latest developments, information, practices and research in the FP/RH field, are produced and currently used by more than 500 organizations in 95 countries.

Institutions' capacity to produce their own CD-ROMs, develop web sites and improve their ability to work with new and traditional technologies needs strengthening. In collaboration with Missions and Regional Bureaus, this sub-result will provide technical assistance and training to select regional and local institutions and programs to create strategies for information dissemination; develop web-sites and list serves; use search engines; and improve dissemination efforts. The implementer will also have the ability to provide small grants (approximately $10,000-30,000 each) to pilot test innovative ways to create, publish, disseminate and exchange information among an organization's affiliates or between knowledge communities within or across countries.

The result will be strengthened local capacity for use of in-country, regional and global information, strategic dissemination of best practices and information, and improvements towards reducing the digital divide between the North and the South as well as within our partner countries.

All three sub-results contribute to each other and collectively to Result 3. The Request for Assistance (RFA) will develop bridges between each of the sub-results to ensure collaboration and synergy and the ultimate success of the Activity Objective.

V. FINANCIAL PLAN

(a) Total Funding Levels

(b) Funding Accounts and Sources

Actions under this AAD will be able to receive funds from a variety of foreign assistance accounts and funds:

- Development Assistance (DA)
- Child Survival and Disease Program Fund (CSD)
- Economic Support Fund (ESF)
- Assistance to Eastern Europe and the Baltic's (AEEB)
- Freedom Support Act (FSA)
- PASAs
- Inter-Agency Agreements
- New Global Development Alliance

Funding for this Communication Activity is expected to come from multiple budgetary sources:

- GH core Population, Child Survival, Maternal Health and Nutrition, HIV/AIDS, and Infectious Diseases (ID) budgets;
- USAID Regional Bureau and Mission Field Support and Modified Acquisition and Assistance Request Documents (MAARDS) budgets for Population, Child Survival, Maternal Health and Nutrition, HIV/AIDS, and ID budgets;
- Global Bureau and Field Support funds from other USAID earmarks and accounts, e.g., CSD funds for girls' education, DG;
- Funds from other donors, especially private foundations;
- In-kind and cash contributions from national and local governments and NGOs in developing countries for implementation of country programs;
- Matching funds provided by CAs/implementing partners.

(c) Use of Core and Field Support Funds

The activity will have a sound base with core GH funds [and Regional Bureau Field Support] to contribute to its technical leadership role, including research, dissemination, capacity-building and coordination activities.

(d) Programmatic and Geographic Allocation of Funds

For illustrative purposes, the following guidance is provided on the allocation of funds by major program areas and regions:

- Over the life of the agreement, it is envisioned that approximately 65 percent of total USAID resources will be allocated for country program implementation support, 20 percent for technical leadership activities and capacity building, and 15 percent for knowledge management and dissemination activities.
- Roughly 40 percent of country program implementation support activities are envisioned to take place in the sub-Saharan Africa region, 30 percent in Asia and the Near East, 15 percent in Latin America and the Caribbean, and 10 percent in Europe and Eurasia. About 5 percent of the activities will be global in scope. The actual distribution of funds and activities across regions, however, will depend on individual Mission interest and availability of Field Support funds.

(e) Cost-Sharing and Program Income

Partners should work towards a significant cost-sharing target of 25 percent per ADS 303.5.10, however, the GH Bureau may reduce the financial participation in accordance with the ADS. Such funds may be mobilized from their own funds, from other multilateral, bilateral and foundation donors, and from host governments or local universities, communities and private businesses that contribute financially and in-kind to implementation of activities at the country level.

As GH's technical leader in communication, the project is expected to mobilize substantial additional program income from other donors. For example, it is envisioned that funds for activities from private foundations focusing on leadership, communication and social change will be leveraged for these activities. In addition, this activity can mobilize funds to help support linkages with other parts of USAID – e.g. conflict mitigation/Health as a Bridge to Peace and broader development activities such as non-formal education, vocational training and formal education programs. Funds for cross-sectoral activities may be mobilized from other USAID sectors and from other donors, national and local governments, universities, local communities and private businesses.

VI. PROCUREMENT PLAN

VII. MANAGEMENT PLAN

Regular briefing and advisory sessions will be set up with staff from Regional Bureaus and other USAID management units, including Missions that provide significant funding to activities under this AAD.

A technical advisory type group or groups will be developed to support this AAD. Specific functions will be finalized in conjunction with the awardees. Representatives should include experts and representatives experienced in the development, design, evaluation, and application of specific health communication activities. Members could be drawn from the public and the private sectors, NGOs, community groups, multilaterals and other international, regional and national organizations. These members will provide input into numerous areas including:

- innovations and strategies at the community level;
- relevance, effectiveness, impact and sustainability of program activities;
- strategic linkages with other initiatives and partners;
- state of the art knowledge and skills in working with youth; and
- a capacity building focus.

VIII. ANALYSES

(a) Stakeholder Analysis

This AAD is built on a fundamental understanding of the knowledge base to date on communication. Information has been compiled through the published literature, USAID reports, field reports, mission surveys, experiences of country implementers, CAs/stakeholders and input from GH Bureau activities.

In preparing the AAD, the GH Bureau engaged in a variety of activities with potential interested parties, other donors, USAID Missions and Bureaus, and other key actors. The first activity included gathering information on what has been done and documented in the field of population and health mass-media communication from 1990-2000. A bibliography of 283 articles was created and a research team reviewed 67 of these articles that were selected on the basis of date published, the article assessed impact and included a mass-media component. The literature review assessed the impact of the various types of mass-media communication interventions with particular emphasis on the level of impact in relation to various other components—theory base, timeframe, and others. Overall, the findings supported investments in communication, attributing significant impact to communication elements. The review of the literature suggested that current and past approaches in health communication are not integrative and evidence-based in the theoretical and practical approaches that impact population-based health behavior change.[29]

Consonant with other studies in this area, including those previously cited in this document by the IOM and the National Academy of Sciences, the review indicates that systematically

[29] CT Orleans. "Promoting the Maintenance of Health Behavior Change: Recommendations for the Next Generation of Research and Practice." *Health Psychology*, 2000 19: 1 (suppl.), 76-93.

developed strategic communication maximizes impact in PHN and HIV/AIDS with emphasis at the individual, community, professional, policy and social level. This literature review was presented at the December 2000 Stakeholders meeting and will be submitted to *International Family Planning Perspectives.*

Also contributing to the current AAD were recommendations from an external evaluation of the PCS project conducted in early 2001. Team members included international communication experts with experience in strategic planning, implementation, and evaluation of communication programs in the developing world. The evaluation found the current project had been generally successful in meeting its objectives and that their work had contributed to lasting beneficial changes in health behaviors as well as to significant advances in development communication science and practice. The proposed AAD addresses the four areas that the evaluation team identified as needing increased attention in USAID's next communication project:

- Expanding the focus beyond individual behavior change and increasing the emphasis on factors related to broader social change.
- Expanding the project's advocacy role to influence decision-makers and policy and regulatory environments, including the use of community advocacy in addressing issues resulting from decentralization.
- Establishing meaningful and measurable standards of performance recognizing the difficulty in establishing causality with communication interventions. This will be particularly relevant for community mobilization activities, as measuring their impact is more complex.
- Intensifying the development of communication skills in host countries that can then be used for technical assistance and training support.[30]

Field perspectives and opinions have been crucial to the design process. Early on in the information gathering stage, USAID field missions were surveyed using a questionnaire that asked about their current and future communication priorities and activities and perceived gaps or emerging issues that the project should address. Almost 50 percent of the 57 missions surveyed responded to the questionnaire, and all indicated that they planned to implement communication activities in the next five years. As mission-funding trends have shown in recent years, most missions plan to use communication across SOs— family planning, HIV/AIDS, infectious disease, and child survival were mentioned most often. Mass media and Information, Education and Communication (IEC) materials are the two most commonly sited types of communication interventions planned. Community mobilization and interpersonal communication also were mentioned frequently, followed by social marketing. Gaps and emerging issues that the field hoped the new project would address included infectious disease (TB was most often named specifically, HIV/AIDS and malaria less often). Addressing the needs of adolescents and developing/expanding private sector partnerships were noted as high priorities, and policy/advocacy and research (tools, Monitoring and Evaluation (M&E), documenting successes) also surfaced as future needs.[31]

Additionally, as part of the design process a short questionnaire was sent to 60 people active in health communication in developing countries not affiliated with US-headquartered international

[30] PCS Evaluation, 2001, pp. 65-67.
[31] USAID Mission Survey, November 2000.

development agencies. Their contributions help support the conceptual framework and design. In particular, they expressed the need for a multi-disciplinary approach with a variety of messages and channels. One of the more notable findings was the fact that communication challenges are often organizational: the agency, department, project, leadership etc. did not understand the impact potential or use of communication. In fact, many identified the low status (pecking order) often associated with communication. The COHC in Result 2 and the multi-disciplinary basis for the entire AAD address these observations that also are consonant with the published literature and other information sources.

Finally, a stakeholders/interested parties meeting was held in June 2001 as well as circulation of a draft for public comment was disseminated to a larger group for public comment. Many of the suggestions have been incorporated into this document.

(b) Social/Gender Analysis

Addressing social/gender issues will be an integral part of this AAD. Communication programs ultimately influence prevailing social norms including the value of women and gender equity, the roles women can and should play in both the home and society, and partner communications and attitudes about sexual and physical violence. Gender is an important variable, therefore, in segmenting audiences for impact in FP/RH, HIV/AIDS and related health challenges.

Involving men in reproductive health programs has become increasingly important at the GH Bureau. Men are a key audience for health messages. As the primary and sometimes sole decision-maker in the family unit, they often control vital resources for accessing health services—fees for clinic visits, transportation to facilities, etc. The activities under this AAD will look at new ways to engage men in health decisions, through a combination of approaches--debate and dialogue on certain cultural practices, through peer communication, or targeted mass-media campaigns.

Addressing the reproductive health needs of youth (including HIV/AIDS and STI prevention) has also become a clear priority for USAID at both the global and field level, but program experience to date, both by USAID and other donors, had been small-scale and lacking in rigorous evaluation.[32] The current POP communication project has devoted about one-third of its resources to reaching youth and appears to be producing genuine impact among this population.[33] Communication programs can help young males recognize that sexual pressure, violence or coercion of any kind is unacceptable, develop more respectful attitudes to girls, and assume greater responsibility for prevention of disease (STIs/HIV) and reproductive health. Activities under this AAD will continue to provide expertise to the field in creating communication interventions that resonate with youth.

The evaluation of the current POP communication project recommended that the gender focus of the project be improved by systematically integrating and acting upon gender analysis in all stages of program cycles and by mainstreaming gender to the project's training materials and approaches[34]. Given this AADs switch in focus from individual behavior change factors related

[32] Judith Sendorwitz, "A Review of Program Approaches to Adolescent Reproductive Health," (Washington DC: Population Technical Assistance Project, 2000).
[33] PCS Evaluation, 2001, p. 26.
[34] PCS Evaluation, 2001, p. 52.

to broader social change, it is critical that gender and cultural sensitivity–the different roles, responsibilities and opportunities of men and women in society-- be addressed throughout the results and sub-results.

(c) Technical Analysis

A growing body of literature is beginning to demonstrate the effects of communication interventions on changing individual and community behaviors in the areas of population, health and nutrition. Communication also has demonstrated success in: influencing the public agenda, advocating for policies and programs, promoting changes in the socioeconomic and physical environments, improving the delivery of public health and health care services, stimulating debate and dialogue for health as a priority, and encouraging social norms that benefit health and quality of life.[35]

The programs designed under this AAD are based on a clear understanding of what works and of the steps needed to increase the impact, cost effectiveness and sustainability of USAID's communication portfolio. This project has been developed and guided by a Bureau-wide technical team that held numerous meetings and discussions, sharing experience, Bureau/field needs and a variety of evidence-based ideas. This AAD was predated by a Concept Paper that built on evidence-based conceptual framework(s) as well as the historical approaches in health communication employed to address the field needs and Bureau objectives.[36]

The design of the AAD also reflects the fact that as the world's largest donor in the field of health communication, USAID's has a two-fold responsibility to: 1) provide USAID Washington and field missions world-class vehicles for implementing communication and advocacy programs within their PHN portfolios, and 2) ensure the transfer of communication capacity and leadership to training institutions and COHC throughout the world.

The understanding that no one size fits all is fundamental to the understanding of the impact of communication. Communication is not a simple solution to a complex problem. Communication is complex, dynamic and requires unique know-how and strategic thinking. For this reason and given the different needs of the GH SOs and of the field missions, the programs under this AAD will range from basic formative and operations research on what works for newer areas such as TB and Anti-Microbial Resistance (AMR) to questioning or exploring how to change social norms, achieve sustainability and go to scale for more mature family planning programs. This AAD provides mechanisms for strategic diagnoses, cutting edge innovation, and taking to scale and transferring what is known.

Effective communication is strategic as well as evidence-based; it is not just message repetition. Effective communication leads to community capacity to espouse common values of health. Attaining the Agency's goals in population, health and nutrition means communicating well with individuals, families and communities. It also means communicating effectively to policymakers and leadership outside of the health sector and making them aware of the critical elements that contribute to health.

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[35] IOM, 2000.

[36] Scott Ratzan, "USAID Communication Activity Acquisition Document Concept Paper," January 2001. Also see R.G. Evans and G.L. Stoddart, "A Model of the Determinants of Health: Predicting Health, Consuming Health Care," *Social Science Medicine*, 31:1347-63, 1990.

IX. COMMUNICATION ACTIVITY CONSTRUCT